STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155106	A. BUILDING 01 B. WING	07/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERWALK VILLAGE	295 WESTFIELD RD NOBLESVILLE, IN 46060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 07/31/12 Facility Number: 000044 Provider Number: 155106 AIM Number: 100274940 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Riverwalk Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated	K0000	The Creation and submission of this Plan of Correction does not constitute an admission by this Provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This Provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review for paper compliance in liew of post survey visit on or after August 17, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	smoke detectors in all resident sleeping rooms. The facility has a capacity of 184 and had a census of 150 at the time of this survey. The facility was found in compliance with the state law in regard to sprinkler coverage and smoke detector coverage. All areas where the residents have customary access were sprinklered. The facility has two detached buildings providing facility services such as a garage and a storage shed which were not sprinklered. Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 08/03/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 1 of 1 openings through the ceiling into the attic above the Clean Utility Room was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect any resident, staff or visitor in the vicinity of the Clean Utility Room by Nurses' Station #1. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:25 a.m. to 2:15 p.m. on 07/31/12, there is a four inch in diameter hole in the ceiling of the Clean Utility Room by Nurses' Station #1 which was not firestopped. Based on interview at the time of observation, the Maintenance Supervisor acknowledged there is a four inch in diameter hole in the	K0025	K025 1) What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?The 4 inch hole in the ceiling located in the clean utility room was fixed and completed closed.2) How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action will be taken?Any residents located near the clean utility room could be affected by the alleged deficient practice.The 4 inch hole in the ceiling located in the clean utility room was fixed by maintenance and completely closed.3) What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? Staff were educated on maintenance request slip forms and use. Upon identification of a maintenance issue needing fixed, staff will document on a	08/17/2012

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	ceiling of the Clean Utility Room by Nurses' Station #1 which was not firestopped. 3.1-19(b)		maintenance work order. Work orders are picked up periodically throught out the day by maintenance. Each work order is completed and dated upon completion.4) How will the corrective action be monitored to ensure the alleged deficient practice does not recur? Maintenance Director and /or designee will provided monthly preventative maintenance room to room rounds to identify and monitor rooms are in accordance with the law. The Executive Director will monitor monthly to ensure ongoing complaince to preventative maintenance.	

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K0029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 1. Based on observation and interview, the facility failed to ensure 1 of 17 doors serving hazardous areas such as soiled linen rooms, automatically close and latch into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity of the soiled linen room by Room 131. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:25 a.m. to 2:15 p.m. on 07/31/12, the entry door to the soiled linen room by Room 131 is equipped with self closing hinge devices but the hinge devices did not swing the door to close and automatically latch into the door frame. Based on interview at the time of observation, the Maintenance Supervisor stated the hinges on the door do not work	K0029	K0291) What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?The door was corrected by maintenance by placing an automatic door closer that latches door to frame automatically.2) How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action will be taken?Residents that live near and around this door on this unit have the potential to be affected by the alleged deficient practice.The door was correctged by maintenance by placing an automatic door closer that latches door to fram automatically.3) What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?During monthly fire drills, maintenance personel will audit doors that protect	08/17/2012

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	and acknowledged the entry door to the soiled linen room by Room 131 does not automatically close and latch into the door frame. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 17 doors serving hazardous areas, such as storage rooms greater than fifty square feet in size and used to store combustible materials, are provided with self closing devices to close and latch the door into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity of Room 234. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:25 a.m. to 2:15 p.m. on 07/31/12, the access door to Room 234 is not equipped with a self closing device to latch the door into the door frame. Room 234 measures 200 square feet and is used to store mattresses, furniture and combustible boxes containing supplies. Based on interview at the time of observation, the Maintenance Supervisor acknowledged Room 234 measures greater than fifty square feet, is used to store combustible mattresses, furniture		hazardous areas to ensure the self closing door is properly working and properly latches to the frame automatically.4) How will the corrective action be monitored to ensure the alleged deficient practice does not recur? Maintenance and/or designee will complete preventative maintence audit of self latching doors to ensure doors properly self close and latch into frame. This audit will be conducted monthly with 100% threshold score. Any door identified not latching will be immediately corrected.	

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	and supplies and the access door is not equipped with a self closing device. 3.1-19(b)			

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K0038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 2 of 7 delayed egress exit doors unlocked when the fire alarm was activated. LSC 19.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6.1(a) requires doors with special locking arrangements such as delayed egress unlock upon actuation of an approved automatic fire detection system in accordance with Section 9.6. This deficient practice could affect any resident, staff and visitors if needing to exit the facility from the exits by Rooms 113 and 125 in Auguste's Cottage. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 11:25 a.m. to 2:15 p.m. on 07/31/12, the delayed egress lock on the exit door by Room 113 and by Room 125 in Auguste's Cottage did not release and remain unlocked when the fire alarm was activated at 1:09 p.m. Based on interview at the time of the observation, the Maintenance Supervisor acknowledged the delayed egress lock on	K0038	K0381) What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?Indiana Electronics Inc (IEI - fire alarm vendor) was immediately called and corrected the two egress doors. Each door now properly unlock when the fire alarm is activated.2) How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action will be taken?Residents residing on the 46 bed unit have the potential to be affected by the alleged deficient practice.IEI was immediately called and corrected the two egress doors. Each door now properly unlocks when the fire alarm is activated.3) What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? During fire drills which occur monthly, maintenence will check egress doors to ensure door automatically and properly unlock when the fire alarm is activated.4) How will the corrective action be monitored to ensure the alleged deficient practice does not recur?During fire drills which occur monthly, maintenence will check egress	08/17/2012

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	the exit door by Room 113 and by Room 125 in Auguste's Cottage did not release and remain unlocked when the fire alarm was activated. 3.1-19(b)		doors to ensure door automatically and properly unlock when the fire alarm is activated.The Executive Director and/or designee will monitor monthly to ensure this practice occurs of monthly audits of egress doors.	

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K0147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 2 of 2 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect any resident, staff or visitor in the vicinity of resident Room 227 and Room 232. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 11:25 a.m. to 2:15 p.m. on 07/31/12, a refrigerator was plugged into a power strip in resident Room 227 and Room 232. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged refrigerators were plugged into power strips in the aforementioned locations. 3.1-19(b)	K0147	K1471) What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?The refrigerators were immediately removed from the use of a power strip in room 227 and 232 and plugged directly into outlet2) How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action will be taken? Any resident residing near or around room 227 and 232 have the potential to be affected by the alleged deficient practice.The refrigerators were immediately removed from the use of a power strip in room 227 and 232 and plugged directly into outlet3) What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?Upon admission, residents and family members will be educated on proper electrical wiring and the inability to use power strips for such items as refrigerators.While cleaning rooms each day, housekeeping staff will assess room to ensure no improper wiring units are being used improperly. Upon identification, housekeeping will inform social service department	08/17/2012

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			to meet with resident and family for alternatives that are in accordance with law.4) How will the corrective action be monitored to ensure the alleged deficient practice does not recur? Maintenance will audit rooms for electrictrical equipment and proper wiring each month. Any identification of improper use will be corrected immediately. The Exectutive Director will monitor monthly to ensure audits are completed and corrected as issues identified.	